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Rural District Council

Annual Report

OF THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1951

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Rural District Council

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KINGSCLERE AND WHITCHURCH RURAL DISTRICT COUNCIL.

PUBLIC HEALTH OFFICERS.

Medical Officer of Health :

JOHN SLEIGH, M.B., Ch.B. (Aberd.), D.P.H. (Edin.).

Chief Sanitary Inspector :

R. A. OVER, A.R.San.I., M.S.I.A.

Additional Sanitary Inspectors :

T. H. JACKSON, M.R.San.I., M.S.I.A.
(resigned 31st July, 1951).

W. E. D. SMITH, M.R.San.I., M.S.I.A.

P. F. THEASBY, M.S.I.A.
(appointed 29th October, 1951).

TO THE CHAIRMAN AND MEMBERS OF THE KINGSCLERE & WHITCHURCH RURAL DISTRICT COUNCIL:

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report for the year 1951.

Once a year the Medical Officer of Health is given the opportunity in his Annual Report of expressing his views on the state of the Public Health not only in his own community but over the wider field, and this opportunity is one which many Medical Officers of Health value highly. It may be that the small attention which may be paid locally to his report means that its result is more to marshall and clarify his own thoughts than anything else, but even that is of value.

It has been said that it takes 30 years from the time a problem and its solution are seen by the few for that problem to be seen by the many, and the solution applied. Consequently the basic problems do not change from year to year and this is as true of the Public Health as of any other field. The report of a Medical Officer of Health, so far as his views on the Public Health are concerned, is therefore bound to show little change from year to year.

The central problem of the Health Services is still exactly as I represented it a year ago and there is no sign of any attempt to apply the remedy. So long as we try to achieve health by treating disease so long must we expect to spend an increasing proportion of our national income on the treatment of disease, for the increase in scientific knowledge is something which will continue at an accelerating rate and the cost of the treatment of disease will increase as research and therapeutics become even more elaborate and expensive. Sooner or later we will realise that we cannot afford to treat the sick, and that we must keep people well.

Our deteriorating economic position is due to external circumstances over which we have no control and the deterioration can be expected to continue. Consequently the necessity for appreciation of the cost of therapeutic medicine is becoming more and more important not only so that the whole policy may be changed but also so that a limit may be agreed beyond which the cost of disease treatment must not increase. The pressure of sheer economic necessity will force the collapse of the present policy.

In 1947 21.4% of the population of England and Wales were aged under 15, 37.4% were aged 15-40, 30.7% were aged 41-64, and 10.5% were aged over 64. In 1962 20.7% will be aged under 15, 33.5% will be aged 15-40, 33.3% will be aged 41-64, and 12.5% will be aged over 64. In 1977 19.2% will be aged under 15, 33.8% will be aged 15-40, 30.8% will be aged 41-64, and 16.2% will be aged over 64*. So the proportion of dependents increases while that of producers falls, and among both dependents and producers the proportion of those most likely to be sick increases (the old in the case of dependents, the older working age group in the case of producers) while the proportion of those least likely to be sick decreases (the young in the case of dependents, the younger working age group in the case of producers) and if we are going to go on trying to achieve health by treating sickness we can certainly expect an increase in the demand. For example since 75% of mental patients are 65 or over, it follows that by 1977 the number of patients will have increased by 47%.

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* Report of the Royal Commission on Population, 1949.

A memorandum which must be viewed in the light of our limited economic resources was issued by the Ministry of Health in 1950† This document purported to indicate to regional hospital boards what was expected of them in the way of provision of specialist services, but as far as can be seen the planners simply accepted without question the extravagant demands put forward by each speciality. They did not investigate the reasonableness of these, nor did they estimate what they would mean to the country when taken together. Dr. Ffrangcon Roberts, of Cambridge, whom I have quoted before, and will no doubt quote again, has made this calculation‡ from the figures contained in the report. According to his estimate it would be necessary, in order to satisfy these demands, to increase the number of hospital beds from 476,000 on 31st December, 1949, to 755,000 or by 63%, and the number of whole-time consultants from 5,000 to 11,000 or by 120%. Dr. Roberts has calculated from the figures for hospital beds that in order to fill these it will be necessary for one in seven of the community to do his duty by spending 18 days in a general hospital each year. So much, as Dr. Roberts says for a healthy nation. The total hospital staff including non-medical personnel came to 220,000 on December 31st, 1949, and if the additional 63% of beds were forthcoming, hospital personnel would have to be increased by 140,000 to 360,000. These 360,000 would come from among the very best of our diminishing labour force, and would be engaged in non-productive employment. The truth is that the authors of this document live in a dream world of their own. As Dr. Roberts says, the Ministry of Health want the consultant services to go to plenty in the midst of poverty! to a medical heaven in the midst of a bankrupt, bedridden, and hungry hell.

At this point it may be of interest to show what is happening to the Health Service estimates from year to year* Whereas in 1950-51 the Hospital Boards were responsible for 59.6% of the total expenditure, in 1951-52 they were responsible for 62.9%, and in 1952-53 they are expected to be responsible for 68.6%. As a stop-gap measure the Government have decided to make a charge for the pharmaceutical, dental and supplementary ophthalmic services, cutting these down from 25.2% of the total in 1950-51 to 21.7% in 1951-52, and 15.4% in 1952-53, but it will be seen that this saving disappears into the ever-willing maw of the hospital services, for the combined total of the two for the three years is 84.8%, 84.6% and 84.0% of the total for the health services. There is a limit to the extent to which one branch of the therapeutic service can be raided to support another, and the hospital service which already takes more than two thirds of the money available cannot be kept going in this manner much longer. As the special correspondent who wrote this article on the Health Service Costs says, expenditure on hospitals could be expanded indefinitely.

Health cannot be achieved by having more hospitals, any more than good cars can be produced by having more repair shops. A manufacturer of motor cars, faced with a defective component in one of his products, would not put up a factory to mend or replace the components. He would find out what was wrong with it and turn out better ones in future. Dr. Roberts realises that Nature is infinitely complex, and that further research into disease and treatment will only disclose ever-widening fields, but his suggestion is that we should develop some system of priorities, when treatment would be provided in proportion to the recipient's ability to return, in the form of service, its cost to the community. This prospect is one which must be repugnant to all who have any humanitarian instinct, but I believe firmly that it is one which will inevitably be forced upon us if we continue with our present policy. If we have only so much to spend on the treatment of the sick we are obviously going to spend it where there is some return, and we cannot go on spending more and more of our total resources in this way. It is not only the materials which go into it, it is the manpower as well.

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† The Development of the Consultant Services.

‡ British Medical Journal, 1952, I, 321.

* British Medical Journal, 1952, I, 759.

There is however, another answer to this problem than that of allocating treatment only where there will be a corresponding return. The doctrine of original disease has come to be accepted by Man, and it never occurs to us to question whether Nature might not have meant us to be healthy. We accept sickness and disease as inevitable and devote our medical services almost entirely to their investigation and treatment. We never stop to question why the incidence of disease is so different in different countries, or even in different parts of the same country. Stocks† in his studies of statistics in England and Wales discovered that for cancer there is a difference of incidence, according to system and organ, among various areas of the same country, and Pascua‡ has found that there is a similar difference of incidence in different countries. Mellanby** reports that there is almost a complete absence of disseminated sclerosis among the South African born white population, and that the incidence of alimentary disorders among the natives of tropical and subtropical countries is much smaller than in Western Europe and America.

Our research should be into health and its attainment, not into disease and its treatment. The treatment of a disease in one individual does nothing to prevent another from acquiring the same condition, nor even to prevent the first from becoming ill again when he returns to the environment (which in its broad sense includes food) which made him take ill in the beginning. It may be argued that such research will be as complex and unrewarding as is our present research. But I believe that what we are going to find in every case is that it was where we went astray from Nature that we were wrong, and that it is only in the direction of aberrations from Nature that we need look for the cause of disease.

Meantime we spend (1951-52) £274.3 million (62.9%) on the Hospital Service, £142.8 million (32.8%) on the Executive Councils (responsible for general practitioner, pharmaceutical, dental and supplementary ophthalmic services) and £18.6 million (4.3%) on the Local Health Authorities. Just think of it! £417.1 million, or 95.7 per cent. for the treatment of disease, £18.6 million, or 4.3 per cent. for the promotion of health.

HOUSING.

No excuse is needed for including some words on Housing. The Housing problem is still the most serious matter affecting the health of the community and as far as can be seen there is every prospect that this situation will continue indefinitely. 172,000 houses were built in England and Wales in 1951 which is exactly the same number as in 1950. I repeat once more that this is exactly half the figure for 1938, (344,000) and that it is less than the number required for replacements (182,000). As a result, the lists of prospective tenants for Council houses continue steadily to increase.

There is no fair way of allocating houses when the number of houses available is less than the number of people who need them. It is impossible to estimate in numerical terms the relative severity of the housing positions of the different applicants and a points scheme however carefully prepared, cannot do more than bring forward the names of those who should be considered next. It is sometimes said that those who have no place of their own should at all times be considered before those who do have a home however unsatisfactory, but this view can perhaps be carried too far. It is seldom satisfactory for a young couple to live with in-laws, but a sub-let where the geography of the house is reasonably good may be a great deal better than ex-Services huts and houses which come under the category of fit for condemnation only.

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† Stocks P. Regional and Local Differences in Cancer Death Rates. General Register Office, 1947.

‡ Epidemiological and Vital Statistics Report of the World Health Organisation, Jan., Feb., 1952.

** British Medical Journal, 1951, II, 865.

There are at present in occupation in this Rural District 178 ex-Services huts and the Hobhouse Survey disclosed that 991 houses were unfit and unsuitable for reconditioning. It is now more than six years since the end of the war, and many of these huts are no longer fit to live in. At the same time the 991 unfit houses are deteriorating and the question arises as to how much longer people can be expected to live in some of them, even if they do not actually become dangerous or fall down. My own view is that it is becoming necessary to rehouse some of the tenants of both huts and houses. The possibility of setting a definite limit to the date at which all these tenants should be rehoused, and of rehousing the appropriate proportion each year might be considered. This would perhaps be too inelastic, but it would at least provide some sort of guide as to how many to rehouse each year.

Another question which I should like to discuss is that of allocation of houses to childless couples and those whose families have grown up and left home. On the one hand it is so much easier for a childless couple to obtain accommodation than it is for one with a family, that it is easy to understand those who say that all houses should go to couples with families; on the other a certain proportion of marriages result in involuntary childlessness and it seems hard that those who want a family and a home should be denied the latter because they cannot have the former. My own view is that a childless couple or one whose family have grown up and left home should be allocated a house only when this results in releasing a suitable home for a couple with a family and that the house they are allocated should be one not suitable for a family. One example would be a childless couple or one whose family have grown up and left home living in a privately owned house which is too big for them and where the landlord is willing to rent it to a couple with a family, and this would also apply to a couple whose family had grown up and left home and who were under-occupying a council house. In my opinion all cases of under-occupation should be dealt with by transferring the tenants to cottages (a much more attractive term than bungalows) whether they request to be transferred or not. The council should pay the removal expenses and the rent of the new house should not be more than that of the old. This procedure is a method whereby the council can provide a family with a house at the cost of building a cottage. Again, my own view is that such cottages should only be built where a house, whether publicly or privately owned, is to be released for a family thereby.

There has been a good deal of talk recently on lowering standards for new houses so that more houses may be built. Now there is no doubt that some of the houses built since the war have been extravagant in some respects, as for example ceiling height and the provision of an extra lavatory (which in any case has not contained a wash basin and is therefore quite wrong) but we must be careful that in reducing standards we do not reduce below what is needed. We have come to accept that a couple with a family need a house with a kitchen, sitting room, bathroom, and three bedrooms, and I hope we will not depart from that standard. It is better to build fewer houses than to build substandard ones. Insofar as our housing problem is partly due to overcrowding, any building of houses which have a reduced number of rooms will only perpetuate that overcrowding.

The trouble is that there are in this country 20,000,000 people whom we cannot feed, and that we must import the food to feed these people, and the raw materials to manufacture into exports to sell to buy that food, while those countries from whom we obtain our food and raw materials are developing their own industries and becoming more and more independent of our exports, so that all the time we are asked more for our imports and offered less for our exports, and an ever increasing proportion of our total production has to go for export as the amount we have to send abroad is increasing more quickly than is our total production. So there is less left for us at home, and we find we can no longer afford for example, the houses, the clothes, or the railway journeys to which we have been accustomed. This is a trend which it appears inevitable will continue, and it would be better if the politicians would cease to offer us (under the aegis of their own party) a future which it is not within their power to grant and would confess frankly that shortages of all kinds, including housing, will not improve and may get worse, so that individuals and families may make up their own minds what to do. Many would choose to remain. This is still the most beautiful country in the world, the one with the highest standard of integrity in its central and local government, and the one with the best climate in the world (with the exception of New Zealand). But many others would choose to go to the Dominions which cannot in any case develop their proved resources because they do not have the people to develop them.

Finally, it may be of interest to compare the number of houses built in Kingsclere and Whitchurch Rural District (population 17,620) since the end of the war with the number which might have been expected had houses been built at the same rate as in all Rural Districts (population 8,068,309). 157,036 permanent houses were built by public and 39,342 by private enterprise and 9,998 temporary houses were built by public enterprise (total 206,376) up to the end of 1951 and on that basis 343 permanent houses might have been built by public and 86 by private enterprise and 22 temporary houses might have been built by public enterprise (total 451) in Kingsclere and Whitchurch Rural District. The actual figures were 356 permanent houses built by public and 82 by private enterprise and 10 temporary houses built by public enterprise (total 448) giving 104%, 95%, 45% and 99% respectively of what might have been expected.

The figures for 1951 alone however are not so satisfactory. 33,706 permanent houses were built by public and 4,950 by private enterprise (total 38,656) and on that basis 73 permanent houses might have been built by public and 11 by private enterprise (total 84) in Kingsclere and Whitchurch Rural District. The actual figures were 57 permanent houses built by public and nine by private enterprise (total 66) giving 78%, 82% and 79% respectively of what might have been expected. Such a deficiency for one year for one authority might easily be explained on the basis of difficulties with individual contracts, and a below average year might well be followed by an above average year, but the other two authorities for which I am Medical Officer of Health, which had also hitherto been up to average, have also had a below average year, and this suggests the possible existence of some adverse factor in this area. Perhaps the answer is to make more use than hitherto of prefabricated permanent houses.

I am indebted to Mr. R. A. Over, A.R.San.I., M.S.I.A., Chief Sanitary Inspector, for his assistance in the preparation of this report (Sections C, D and E).

I have the honour to be,
Mr. Chairman, Ladies and Gentlemen,
Your obedient servant,
JOHN SLEIGH,

SECTION A: STATISTICS AND SOCIAL CONDITIONS OF THE AREA.

(1950 figures in brackets).

Area (in acres)	77,394	(77,394)
Registrar General's estimate of resident population	18,640	(17,620)
Number of inhabited houses according to Rate Books	5,292	(5,194)
Rateable value	£102,331	(£100,832)
Sum represented by a penny rate	£426	(£420)

CHIEF INDUSTRIES IN THE AREA.

Below are given Ministry of National Insurance figures of numbers employed, obtained from the Ministry of Labour. It is not possible to give figures for the Rural District of Kingsclere and Whitchurch as Ministry of National Insurance areas are based not on existing Local Government areas but on the towns and the areas of country draining naturally into them. The figures given are for the area of the Andover office of the Ministry of National Insurance, which area comprises :—

Andover Municipal Borough.

Andover Rural District.

Hurstbourne Priors, Laverstoke, St. Mary Bourne, Whitchurch, and Portals only in Overton, in Kingsclere and Whitchurch Rural District.

Broughton, Houghton, Leckford, Longstock, Nether Wallop, Over Wallop and Stockbridge, in Romsey and Stockbridge Rural District.

Agriculture	2,000
Paper Making and Printing	1,600
Local and National Government	1,400
Building	1,300
Distributive Trades	1,100
Engineering, Garages, etc.	1,100
Food and Drink, etc.	500
Woodwork, etc.	500
Transport	350
Professions	180
All others	1,670
Total	11,700

EXTENT OF UNEMPLOYMENT.

This is virtually non-existent, being 0.1% (England and Wales 1.4%)

VITAL STATISTICS.

(1950 figures in brackets).

	Kingsclere and Whitchurch R.D.		England and Wales	
Births	Rates per 1000 Home Population.			
Live births	16.9	(19.9)	15.5	(15.8)
Still births	0.38	(0.23)	0.36	(0.37)
Deaths.				
All causes	12.4	(12.0)	12.5	(11.6)
Typhoid and paratyphoid	0.00	(0.00)	0.00	(0.00)
Whooping cough	0.00	(0.00)	0.01	(0.01)
Diphtheria	0.00	(0.00)	0.00	(0.00)
Tuberculosis	0.00	(0.23)	0.31	(0.36)
Influenza	0.21	(0.00)	0.38	(0.10)
Smallpox	0.00	(0.00)	(0.00)	—
Acute poliomyelitis (including polioencephalitis)	0.00	(0.00)	0.00	(0.02)
Pneumonia	0.59	(0.28)	0.61	(0.46)
Notifications (corrected)				
Typhoid fever	0.00	(0.00)	0.00	(0.00)
Paratyphoid fever	0.00	(0.00)	0.02	(0.01)
Meningococcal infection	0.05	(0.00)	0.03	(0.03)
Scarlet fever	0.64	(1.76)	1.11	(1.50)
Whooping cough	1.77	(5.51)	3.87	(3.60)
Diphtheria	0.00	(0.00)	0.02	(0.02)
Erysipelas	0.32	(0.23)	0.14	(0.17)
Smallpox	0.00	(0.00)	0.00	(0.00)
Measles	10.19	(3.01)	14.07	(8.39)
Pneumonia	2.31	(1.36)	0.99	(0.70)
Acute poliomyelitis (including polioencephalitis)				
Paralytic	0.00	(0.00)	0.03	(0.13)
Non-paralytic	0.00	(0.06)	0.02	(0.05)
Food poisoning	0.00	(0.00)	0.13	(0.17)
Deaths	Rates per 1000 Live Births			
All causes under 1 year of age	38.1	(14.3)	29.6	(29.8)
Enteritis and diarrhoea under 2 years of age			1.4	(1.9)
Notifications (corrected)	Rates per 1000 Total (Live and Still) Births			
Puerperal fever and pyrexia	3.11	(0.00)	10.66	(5.81)

BIRTH RATE.

The Birth Rate for 1951 (16.9 per 1000) was 1.4 per 1000 above that for England and Wales (15.5 per 1000). The most important factor affecting the birth rate in any one area as compared with that in the country as a whole is opportunity for marriage as the number of babies born in any one family depends more on the age of the marriage of the parents than on any other factor. The suggestion is therefore that there is some influence in Kingsclere and Whitchurch Rural District advancing the date of marriage. Unemployment is nil which is likely to be one factor and the only other factor that suggests itself is the presence in the district of large numbers of young men in the forces, etc. I do not think that the birth rate even in this district is adequate for replacement purposes.

However, we should not forget that the birth rate for England and Wales is itself well below replacement level. On the basis of current mortality experience only about three quarters of the children needed to maintain the population at its present level are being born. The population is still increasing as a result of the increased expectation of life, but this cannot be expected to continue for we are now at the stage when nearly all will die of old age, and we have not yet been able to influence the onset of ageing. Unless we become able to do this, the population will ultimately fall by a quarter in each generation. In any case even if the population does not decline for some time the proportion of the young and of the producers will fall and that of the old and of the non producers will rise. While in December, 1951, the population under 15 years was 22.1 per cent. of the whole, it will be only 20.3 per cent. in 40 years' time. During the same period, the proportion of women aged 15-44 to the whole population is expected to fall from 21.4 per cent. to 19.8 per cent. whilst the number of men aged 65 and over and women aged 60 and over will increase from 4.5 and 9.3 per cent. respectively to 6.9 and 12.5 per cent. respectively*. These figures make allowance for a continued improvement in mortality experience which is not in my opinion justifiable, on the current figures, and they are in my opinion over optimistic. In the financial year 1952-3 the Exchequer will pay £37,000,000 into the National Insurance Fund to enable income to cover expenditure. But by 1957-8 the sum will have risen to £150,000,000 and by 1977-78 the Exchequer contribution will have grown to nearly £450,000,000.† This heavy liability in the years to come is due to the ageing of the population and the consequent increase in the expenditure on retirement pensions.

So although our economic difficulties are due to the fact that we have 20,000,000 people whom we cannot feed, the necessity for maintaining our population at its present level is paramount. A declining population is inevitably one in which the older people outnumber the younger, and in which the smaller proportion of active people must work increasingly harder to support the greater proportion of non-active. The only kind of population decline which is not accompanied by this state of affairs is one brought about by planned emigration of cross sections of all age groups of the community. It is interesting to note that the Commonwealth, above all Canada and Australia, cannot develop their resources for want of people.

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* Registrar General's Provisional Vital Statistics for 1951.

† British Medical Journal, 1952, I, 207.

We used to produce children to look after us in our old age. Now we expect the State to do it. But the State can only do it by allocating to the old by means of pensions a proportion of the production of the young. The amount available for distribution is dependent upon the number of producers and the real value of pensions cannot be maintained for more pensioners by fewer producers. We are badly in need of a real population policy in this country whereby people should be encouraged to have children. Nowadays children are a liability because they can no longer be exploited for financial gain by their parents at an early age. We want to assist people to have children by giving adequate family allowances, income tax reliefs, educational and housing provision, and so on, but as well as this we must alter the present attitude of the community to the parents of more than one or two children that there is something indecent or uncivilised in their action, let alone that it is downright stupid or must have been a mistake.

DEATH RATE.

The death rate for 1951 (12.4 per 1000) was 0.1 per 1000 below that for England and Wales (12.5 per 1000).

Infant Mortality Rate.

The infant mortality rate for 1951 (38.1 per 1000) was 8.5 per 1000 above that for England and Wales (29.6 per 1000). No significance should be attached to a rate of this size for a small authority.

Analysis of Mortality and Case Rates for Certain Infectious Diseases.

No significance can be attached to the rates given for this Authority as the population is too small. It is hoped, however, that it will be of some interest to compare them with those for England and Wales. Probably the only figures for which any explanation is required are the measles case rates for this Authority, for this year and last, this year's being high and last year's low. This is due to the fact that although measles occurs more or less equally each year for the country as a whole, it occurs in each area in alternate years as it takes two years for the level of immunity in the community to fall as a result of new births to the point at which an epidemic can recur.

It is hoped that it will be noted that the mortality rate for England and Wales for poliomyelitis is nil and that the case rate for England and Wales for poliomyelitis is one third of that for food poisoning and erysipelas, one twentieth of that for qneumonia, one twenty-second of that for scarlet fever, one seventy-seventh of that for whooping cough, and one two hundred-and-eighty-first of that for measles. Perhaps this may assist towards the preservation of a sense of proportion about the importance of poliomyelitis.

Vital Statistics : 1938 - 1951

Year	Population	%	E & W	Births	B R	E & W	Deaths	D R	E & W	I M	I M R	E & W
1938	15100	100	100	209	13.8	15.1	169	11.2	11.6	6	28.7	53.0
1939	15810	104.7	100.6	201	12.7	15.0	163	10.3	12.1	6	29.9	50.0
1940	17130	113.4	96.8	242	14.1	15.2	233	13.6	14.4	12	49.6	56.0
1941	19000	125.8	94.0	261	13.7	14.2	227	11.9	12.9	9	34.5	59.0
1942	18070	119.7	92.8	277	15.3	15.8	214	11.8	11.6	12	43.3	49.0
1943	17290	114.5	91.8	274	15.8	16.5	190	11.0	12.1	11	40.1	49.0
1944	17060	113.0	91.7	300	17.6	19.9	219	12.8	12.7	8	26.7	45.0
1945	16340	108.2	92.0	278	17.0	16.1	200	12.2	11.4	15	54.0	46.0
1946	16230	107.5	98.5	276	17.0	20.2	170	10.5	12.0	11	39.9	43.0
1947	16290	107.9	101.4	346	21.2	20.5	195	12.0	12.0	13	37.6	41.0
1948	17010	112.6	103.7	333	19.6	17.9	170	10.0	10.8	10	30.0	34.0
1949	17540	116.2	104.6	300	17.1	16.7	178	10.1	11.7	4	13.3	32.0
1950	17620	116.7	106.3	350	19.9	15.8	201	12.0	11.6	5	14.3	29.8
1951	18640	123.4	106.3	315	16.9	15.5	231	12.4	12.5	12	38.1	29.6
	Total			3962			2760			134		
	Average				16.6	16.7		11.6	12.1		34.3	44.0

Population 1951	18640
Population, 1938	15100
Total Increases	3540
Births, 1938-51	3962
Deaths, 1938-51	2760
Natural Increase	1202
Total Increase	3540
Natural Increase	1202
Immigration	2338

This year I also include a table giving Population, Population expressed as a percentage of the 1938 Population, Population of England and Wales expressed as a percentage of the 1938 Population, Births, Birth Rate, Birth Rate of England and Wales, Deaths, Death Rate, Death Rate of England and Wales, and Infant Mortality, Infant Mortality Rate, Infant Mortality Rate of England and Wales, for each year from 1938, the last complete pre-war year, to 1951. It is hoped that this table showing the changes over a very eventful period will be of interest.

Population.

While the population of England and Wales declined steadily from 1939 until 1944, and then increased steadily until 1950, the population of Kingsclere and Whitchurch Rural District increased steadily from 1938 until 1941, then decreased steadily until 1946 and then increased steadily until 1951. While the 1951 population of England and Wales was 6.3% above that for 1938, the 1951 population of Kingsclere and Whitchurch Rural District was 23.4% above that for 1938.

Births.

While the birth rate for England and Wales declined in the early years of the war and then increased until 1947, the birth rate for Kingsclere and Whitchurch Rural District was stationary at first and then increased until 1947. Since then both have declined. Kingsclere and Whitchurch Rural District's average birth rate over the period was 16.6, as against 16.7 for England and Wales but although Kingsclere and Whitchurch Rural District's was lower than that for England and Wales until 1946 (with the exception of 1945) it has been higher since 1947.

Deaths.

Apart from the big increase in 1940, there has not been a great deal of fluctuation in the death rate either for Kingsclere and Whitchurch Rural District or for England and Wales. The two have followed one another fairly closely with England and Wales lower in four years, Kingsclere and Whitchurch Rural District lower in nine, and the same rate for both in one. Kingsclere and Whitchurch Rural District's average of 11.6 compares with that of 12.1 for England and Wales.

Infant Mortality.

These rates vary widely in the case of Kingsclere and Whitchurch Rural District as can be expected from a relatively small population and probably it would be necessary to take each year with that preceding and that following to get a reasonably smooth curve. Apart from 1945 and 1951 the rate for Kingsclere and Whitchurch Rural District has always been below that for England and Wales, but the gap is now narrowing because Kingsclere and Whitchurch Rural District's rate has always been much nearer what is in the present state of medical knowledge, the irreducible minimum. Kingsclere and Whitchurch Rural District's average of 34.3 compares favourably with that of 44.0 for England and Wales.

I have also included below the main table three small ones showing total increases in population over the period, natural increase (excess of births over deaths) and by calculation from the two former figures, immigration during the period. The population increased by 3,540, births exceeded deaths by 1,202, and immigration was 2,338. At four to a house it would require 585 houses to provide for these immigrants alone without providing for replacement of existing houses and Kingsclere and Whitchurch Rural District's total of new houses to date is 448.

Live Births	Male		Female		Total	
Legitimate	153	(156)	142	(179)	295	(335)
Illegitimate	13	(9)	7	(6)	20	(15)
Total	166	(165)	149	(185)	315	(350)

Still Births	Male		Female		Total	
Legitimate	1	(3)	6	(1)	7	(4)
Illegitimate	0	(0)	0	(0)	0	(0)
Total	1	(3)	6	(1)	7	(4)

Deaths of Infants under 1 year of age	Male		Female		Total	
Legitimate	4	(3)	7	(2)	11	(5)
Illegitimate	0	(0)	1	(0)	1	(0)
Total	4	(3)	8	(2)	12	(5)

Deaths of Infants under 4 weeks of age	Male		Female		Total	
Legitimate	3	(3)	5	(2)	8	(5)
Illegitimate	0	(0)	0	(0)	0	(0)
Total	3	(3)	5	(2)	8	(5)

Deaths	Male		Female		Total	
Tuberculosis, respiratory	0	(2)	0	(0)	0	(2)
Tuberculosis, other ...	0	(1)	0	(1)	0	(2)
Syphilitic disease ...	0	(0)	0	(0)	0	(0)
Diphtheria	0	(0)	0	(0)	0	(0)

Deaths	Male		Female		Total	
Whooping cough	0	(0)	0	(0)	0	(0)
Meningococcal infections	0	(0)	1	(0)	1	(0)
Acute poliomyelitis ..	0	(0)	0	(0)	0	(0)
Measles	0	(0)	0	(0)	0	(0)
Other infective and parasitic diseases ...	0	(0)	0	(0)	0	(0)
Malignant neoplasm, stomach	2	(0)	0	(1)	2	(1)
Malignant neoplasm, lung bronchus ...	3	(4)	3	(0)	6	(4)
Malignant neoplasm, breast	0	(0)	5	(3)	5	(3)
Malignant neoplasm, uterus	0	(0)	1	(0)	1	(0)
Other malignant and lymphatic neoplasms	12	(11)	5	(9)	17	(20)
Leukaemia, aleukaemia	1	(1)	1	(1)	2	(2)
Diabetes	0	(1)	1	(3)	1	(4)
Vascular lesions of nervous system	11	(8)	18	(21)	29	(29)
Coronary disease, angina	8	(10)	5	(5)	13	(15)
Hypertension with heart disease	2	(2)	5	(1)	7	(3)
Other heart disease ...	28	(34)	29	(33)	57	(67)
Other circulatory disease	3	(5)	6	(1)	9	(6)
Influenza	1	(0)	3	(0)	4	(0)
Pneumonia	5	(3)	6	(2)	11	(5)
Bronchitis	3	(1)	4	(1)	7	(2)
Other diseases of respiratory system	4	(0)	1	(0)	5	(0)
Ulcer of stomach and duodenum ...	2	(0)	2	(0)	4	(0)
Gastritis, enteritis, and diarrhoea	2	(1)	1	(0)	3	(1)
Nephritis and nephrosis	3	(1)	3	(0)	6	(1)
Hyperplasia of prostate	2	(2)	0	(0)	2	(2)
Pregnancy, childbirth, abortion	0	(0)	0	(0)	0	(0)
Congenital malformations	1	(1)	1	(1)	2	(2)
Other defined and ill-defined diseases ...	21	(12)	13	(8)	34	(20)
Motor vehicle accidents	0	(3)	1	(0)	1	(3)
All other accidents ...	0	(3)	1	(3)	1	(6)
Suicide	1	(1)	0	(0)	1	(1)
Homicide and operations of war	0	(0)	0	(0)	0	(0)
All causes	115	(107)	116	(94)	231	(201)

THE CHEMICAL MANIPULATION OF FOOD

The insertion of some information on this subject immediately following the " Deaths " table is intentional. It is my opinion that the increase in the diseases of civilization or degenerative diseases, such as cancer, cerebral haemorrhage, coronary thrombosis and angina pectoris and peptic ulcer is caused by the unnatural nature of our diet. Diseases other than the degenerative diseases are decreasing, and surely faulty nutrition is the most likely explanation of the increase in the latter. The incidence of these diseases is much greater in Western countries, and the obvious explanation is that this is due to modern errors of living, of which the ingestion of chemically treated food is the most obvious. Chemicals may not only confer toxic properties on food, they may by their action remove or destroy important constituents or dilute the nutritional constituents with air or water.

Of the four sweetening agents that have been in use, two including saccharin have not been found to cause any damage, but of the other two one caused liver tumours and the other kidney damage. The most commonly used colouring substance in food belongs to the azo-dye group. In the United States and Canada only those azo-dyes may be used which are specified as harmless, but in this country all those azo-dyes may be used which are not specified as harmful. Among those which have been found to be harmful, a large number cause malignant tumours of the liver, including one with the euphemistic title of butter-yellow, and these azo-dyes are all of the same group as those others used for colouring food.

White flour is so widely used as an article of diet that the substances used in the treatment of flour are of particular interest. The best known is nitrogen trichloride which is a bleacher and (another euphemism) improver, that is to say it makes the loaf lighter by allowing more air and gas to be incorporated so that a slice of given volume contains less nutriment. Agene (as nitrogen trichloride is popularly known) has been proved to cause hysteria in dogs, and in fact no species of animal tested with the substance produced by nitrogen trichloride by action on the flour has failed to show toxic symptoms of the central nervous system. There is certainly a big enough increase in nervous disease to justify consideration of this matter, but although the United States have given up nitrogen trichloride it is still used in this country. It is also worth mentioning that the toxic substance which nitrogen trichloride produces by action on the flour is formed by the destruction of a valuable constituent of the flour, so that the customer has a food replaced by a possible poison. There is no certainty that any other bleacher or improver which may be used may not ultimately be found to have the same two effects.

Another group of widely used chemicals in food are the emulsifiers, which make flour confectionery more tender. Certain of these if impure are actually poisons and this emphasises the importance of purity of these products. But there is evidence that even in the pure state certain emulsifiers cause gastro-intestinal disturbances. There is no lack of gastro-intestinal complaints in this country today, but although the number of emulsifiers which may be used in food has been very strictly reduced in the United States, nothing has been done here.

Even where chemicals do not actually cause harm they may reduce the nutritive value of food, by taking the place of other ingredients which are of food value. We can no longer rely on our senses to tell us whether food is what it should be. The fat-sparers come in this category, as their name implies, and they are widely used. The flour " improvers " have already been mentioned.

The last category I would like to include are the pesticides, chemicals used in agriculture. Many of these in large doses are very toxic, and while the concentration used in spraying may not be high, they are absorbed into the plant. These chemicals in high concentration cause cancer of the liver in aimals, and the significant feature is that they are absorbed and stored by the body over long periods with a cumulative effect. Many people engaged in the preparation and use of these substances have been killed or injured by them, but much the more important question is, what happens to the consumer?

In this country the Ministries responsible for our food are those of Food and of Agriculture and Fisheries. Now the objectives of these two Ministries must be to produce as much food as possible and food which the consumer finds acceptable, and these objectives must conflict with that of the effect of food on health. It would be much better if the responsibility for all questions involving the addition of unnatural chemicals to food rested with the Ministry of Health.

At several points I have shown that practice in the United States is much ahead of that in this country. There is in the United States a large and important department called the Food and Drugs Administration, which is responsible for this question of the addition of chemicals to food and this provides the explanation for progress there. In this country the only organisation is the toxicological research unit of the Medical Research Council but its objectives are quite different and much more limited. The position is that we are in the undignified position of having to rely on the decisions arrived at in the United States before policy or action can be determined here. It is not as if the questions at issue were small and of rare occurrence. Questions of great public interest are constantly coming up, and the Food and Drugs Administration is very active. The establishment of a similar department in this country is long overdue.

For much of the information given above I am dependent on an article by Sir Edward Mellanby in the British Medical Journal 1951, II, 863, but it ties up with what I said on the subject of food in my last annual report. What is most important in food is that it should be fresh, natural and wholesome, not processed, sophisticated, and adulterated. Foot and mouth disease is much in the news just now, and I repeat again that Sir Albert Howard found that cattle fed on pasture fertilised by returning to it the whole of the animal and vegetable refuse of the community could actually rub noses across a fence with cattle suffering from foot and mouth disease without contracting the infection. Mr. Friend Sykes who farms some seven miles from Andover has eradicated contagious abortion by similar means and at a meeting which I suggested of the Southern Branch of the Society of Medical Officers of Health he spoke of this and other achievements with animals and with crops. Sir Robert McCarrison found that whereas rats fed on natural food grew well, had little disease and lived happily together, those fed on processed food grew ill, had much disease and lived unhappily together, the strong killing and eating the weak. There, if anywhere is a parable for the times in which we live.

If it was even accepted as a principle that where possible fresh natural and wholesome food should be the objective, much would be gained. A moment's thought shows that this objective is very far from being considered today. The latest proposal is to add fluorine to water, as fluorine has a proved effect in postponing the onset of dental decay, although it is not proved that it prevents it. But there is ample fluorine for this purpose in the wheat berry which we throw away when we make white flour. Maybe water should have fluorine added, but I would like first to see a study of the comparative mortality figures for the degenerative diseases in those areas which already have naturally a high fluorine content in their water.

Smoking and Cancer of the Lung.

Last year I included a note on a recent statistical investigation of the relationship between smoking and cancer of the lung, and as it is an obvious example of preventive medicine, I include it again with additions.* Whereas among a control group of men and women without cancer of the lung 4.2% of the men and 53.3% of the women were non-smokers, among a group of 649 men and 60 women with cancer of the lung only 0.3% of the men and 31.7% of the women were non-smokers. Whereas among the control group 13.5% of the men and 0% of the women smoked 25 or more cigarettes a day, among the group with cancer of the lung 26% of the men and 14.6% of the women smoked 25 or more cigarettes a day. It was calculated that above the age of 45 the risk of cancer of the lung was 50 times as great among those who smoked 25 or more cigarettes a day as among non-smokers. During the 25 years between 1922 and 1947 the annual number of deaths recorded in England and Wales increased from 612 to 9,287. During the nine years between 1940 and 1947 the annual number of deaths recorded in England and Wales increased from 5,227 to 11,182.† Between 1949 and 1950 the death rate for cancer of the lung for men of England and Wales rose from 484 to 530 per million population‡. Cancer takes 10-15 years to develop, and the spectacular increase in smoking has been since 1939. What its results will be remain to be seen. What is the responsible factor in cigarettes is not known but the obvious advice to anyone contemplating taking up smoking is " Don't."

SECTION B: GENERAL PROVISION OF HEALTH SERVICES FOR THE AREA.

National Health Service Act, 1946.

Local Health Services under Part III.

In paragraph 20 of Ministry of Health circular 112/47 it was recommended that all counties should be subdivided according to local health requirements, that in each subdivision the County Health Committee would use its powers (under paragraphs 6 and 7 of Part II of the Fourth Schedule to the Act) to appoint a Sub-Committee on which the Councils of County Districts comprising the subdivision would be represented, and to which would be delegated the day to day administration in the division of the Part III (Local Health Authority) Services of the National Health Service Act, and that, under the County Medical Officer, executive charge of these in the division would be taken either by an existing Assistant County Medical Officer, preferably one who was also Medical Officer of Health of one or more of the districts constituting the Division or by the Medical Officer of Health of one of these districts, who would be appointed to the staff of the County Medical Officer. The County Council as the Local Health Authority would of course retain its responsibility for policy and finance unimpaired but to day to day administration the Sub-Committee would bring the local interest and knowledge which are so desirable in such personal services.

In paragraph 7 of Ministry of Health circular 27/51 county councils were again recommended to have regard to the advantages which might be expected to flow from a plan, which besides providing for a single officer to hold the office of medical officer of health for two or more county districts where this was appropriate, also provided for him to be employed part-time in county council services and so to help to administer the personal health services of the county council in the area in addition to discharging the duties which fell to him, as county district medical officer of health. The Minister was sure that such arrangements were in the interests of the local services as well as of the officers themselves, because they secured to those services the help of medical officers experienced in the administration of both kinds of local health services—environmental and personal. The marked growth in recent years of arrangements of this kind was itself sufficient testimony of their value and practicabilty.

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*British Medical Journal 1950, II, 739.

†British Medical Journal 1951, II, 235.

‡Medical Officer, 1952, I, 202.

The recommendations of the Delegation Sub-Committee of the Local Government Manpower Committee which were published by the Committee and which were endorsed by the then Minister of Local Government and Planning, included recommendations similar to those of Ministry of Health Circular 118/47.

A memorandum agreed by the Council of the Society of Medical Officers of Health, which was published by the Society, stated that the Society of Medical Officers of Health was in favour of decentralisation of National Health Service Part III functions by county councils wherever practicable. that the Society considered that such decentralisation should be to sub-committees of county health committees (as authorised by the Fourth Schedule Part II, paragraphs 6 and 7) which should be responsible for day to day administration of some or all of the Part III Services, that the medical officer appointed to serve the sub-committee normally had other duties to perform and might be medical officer of health of one or more of the county districts in the area, that so far as the medical officer's duties under Part III of the National Health Service were concerned he acted as a senior member of the staff of the county medical officer, and that policy, finance, and establishment were retained as functions of the central committee.

Even up to 1949 (no more recent figures are available) 31 of the 62 Counties in England and Wales had carried out the recommendations of the Minister of Health contained in paragraph 20 of circular 118/47, but no such subdivision has taken place in Hampshire. Charge of duties under Section 26 (Vaccination and Immunisation) is taken by the medical officer of health, but charge of duties under Sections 22 (Care of Mothers and Young Children), 23 (Midwives), 24 (Health Visitors), 25 (Home Nursing), 27 (Ambulance), 28 (Prevention of Illness, Care, and After-Care) and 29 (Domestic Help) remains with the County Medical Officer. The District Health Sub-Committee has advisory functions only in connection with Sections 23 (Midwives), 25 (Home Nursing) and 29 (Domestic Help) only, but the officers carrying out these services come directly under the control of the County Health Committee and are in no way answerable to the District Health Sub-Committee.

Section 26 (Vaccination and Immunisation).

This is therefore the only one of the Part III (Local Health Authority) Services under the National Health Service Act on which I am able to report.

Notification of birth cards received by the County Medical Officer from the Health Visitors are sent to the Medical Officer of Health, who prepares Diphtheria Immunisation Record Cards from them, and these form a Diphtheria Immunisation Card Index. Consent cards received by parents from the Health Visitors are sent to the Medical Officer of Health who sends the corresponding Diphtheria Immunisation Record Cards to the general practitioners and they perform the immunisation. A Diphtheria Immunisation Clinic is also conducted by the Medical Officer of Health with the assistance of the Health Visitors at the Health Centre, Junction Road, Andover, at 11 a.m. on the first Saturday in the month for those children whose parents wish them to be immunised by him.

Diphtheria Immunisation.

ANNUAL RETURN FOR YEAR ENDED 31st DECEMBER, 1951.

Number of children who completed a full course of Primary Immunisation in the Authority's area (including temporary residents) in the above year.			Total number of children who were given a secondary or reinforcing injection (i.e.: subsequent to complete full course).
Age at date of final injection.		Total	During the year ended 31st Dec., 1951.
Under 5	5 to 14		
305	0	305	356

The figures of 356 for total number of children who were given a secondary or reinforcing injection (i.e. subsequent to complete full course) compare with 146 for the previous year and are the result of a campaign to improve the state of immunity of the school children.

A letter was prepared by the Medical Officer of Health giving details of the advisability of primary and reinforcing immunisation and requesting return of an attached consent form giving details of who it was desired should carry out the immunisation and of the child's immunisation state. Copies of this letter were sent to the Head Teachers of all Primary Schools for distribution to all children (not to those aged 5 and 10 only who are normally the only ones who receive reinforcing immuunisation, as many children aged six to nine had escaped reinforcing immunisation in recent years). Consent forms completed by the parents were returned by the Head Teachers to the Medical Officer of Health and were examined to see whether the child required reinforcing immunisation. Where the parent had requested that the Medical Officer of Health should carry out the immunisation, Diphtheria Immunisation Reinforcing Injections Record Sheets were prepared and sent to the general practitioners who were asked to carry out the immunisations at the schools on behalf of the Medical Officer of Health, with payment on a sessional basis, the schools being allocated among them proportionately and with regard to the area of their practice. Where the parent had requested that the general practitioner should carry out the immunisation, Diphtheria Immunisation Record Cards or Diphtheria Immunisation Reinforcing Injections Record Sheets were prepared and sent to the general practitioners, with payment on a *per capita* or sessional basis respectively, depending on the number on a immunised. Arrangements for all sessions were made by the Medical Officer of Health. Unfortunately some of the general practitioners were unable to carry out the immunisations before the end of the year and it is feared that the Diphtheria Immunisation Reinforcing Injections Record Sheets may have become out of date due to children moving on to the secondary schools or leaving the district, and that children who should have been immunised may have been missed. However this has worked fairly well and there has been a considerable increase in the proportion of children who have received a reinforcing injection. It is considered that in future years it will be necessary to send the letter to the parents of children aged five and 10 only.

Immunisation in Relation to Child Population.

Number of children at 31st December, 1951 who had completed a course of immunisation at any time before that date (i.e. at any time since 1st January, 1951).

Age at 31 Dec. 51: ie. Born in year	under 1 1951	1 1950	2 1949	3 1948	4 1947	5 to 9 1942-1946	10 to 14 1937-1941	Total under 15
Number immunised ...	19	316	195	415	436	455	156	1992
Estimated mid-year child population 1951	Children under 5 1546					Children 5 to 14 2762		4308

Diphtheria Notifications and Deaths in Relation to Immunisation during the year 1951 Nil.

The 1,381 immunisations performed on the 1,546 children under 5 represent a percentage of 89.3, the 611 immunisations performed on the 2,762 children from 5-15 represent a percentage of 22.1, and the 1,992 immunisations performed on 4,308 children under 15 represent a percentage of 46.2.

These percentages for 1951 may be compared with 89.6 per cent. 16.7 per cent. and 42.6 per cent. for 1950, and show an improvement. They may also be compared with 61.6 per cent. 69.0 per cent and 66.3 per cent. for rural districts, and with 57.0 per cent, 68.3 per cent. and 63.9 per cent. for the County for 1950. It will be seen therefore that our percentages for under 5's are 27.7 per cent. above those for rural districts, and 32.3 per cent. above those for the County, for the previous year, but our percentages for 5's to 15's are 46.9 per cent. below those for rural districts, and 46.2 per cent. below those for the County for the previous year, and our percentages for all children are 20.1 per cent. below those for rural districts and 17.7 per cent. below those for the County, for the previous year. These figures represent the result of a complete search through all our records, and indicate that these records are obviously very far from complete.

The cause of this apparently unsatisfactory state of affairs is the return itself. It will be seen that it demands figures dating back to 1937, that is 15 years old. But what is even more unfortunate is that the return was only introduced in 1945, in which year it demanded figures dating back to 1931, that is 15 years old at that time. It is most unlikely that all the figures submitted at that time were based on records and many of them must have been estimates. Because of the peculiar nature of the return, later figures based on records have been added each year to those earlier figures, conferring on them an appearance of accuracy to which they may not have been entitled. The accuracy of this return in every case will not really be certain until 15 years from the date of its introduction and comparisons based on returns at the present time are not necessarily of any great value. It will be seen also that figures for immunised children between the ages of 5 and 14 are given in two 5 year age groups which in each year's return refer to two groups of 5 calendar years a year later than the two groups of the previous year's return, so that the return cannot be based on that for the previous year, but only on the records on which that return was based. In the case of this Authority, the only records which I was able to find give the figures which I have set out above. Because of the nature of the return, it is not unlikely that many authorities submit returns based on estimates.

The Decline in Diphtheria Immunisation.

The drop of nearly 27,000 in immunisations done in the first months of 1950 as compared with the same period in 1949 was followed by a drop of over 140,000 in immunisations done in the 0-5 age group, in the whole year as compared with 1949, 433,000 as compared with 574,000. Fortunately there was a large recovery to 497,000 in 1951, but this is still well short of the 1949 figure and it is the overall level of immunity in the population that is important in preventing the spread of the disease, so that it is most important to recover the ground lost. Fear of diphtheria is declining, and the very success of the immunisation campaign in almost eliminating diphtheria has led to some apathy on the part of mothers who do not realise that this is conditional upon the maintenance of an adequate level of immunisation. In 1951 deaths numbered 34 against a yearly average of about 2,800 between 1930 and 1940, and notifications (uncorrected) were 1,983 and (corrected) 699 compared with a yearly average of 55,000 in the same decade. The fall in the numbers of cases and deaths is due to the immunisation campaign. Over the three year period 1945-47 the notification rate among children under 15 in England and Wales was three times higher, the death rate was 22 times higher, and the fatality rate (deaths per cent. of notifications) was seven times higher, among the non immunised than among the immunised children.* The condition is not becoming less serious. Over the eight year period 1944-51 the fatality rate (deaths per cent. of notifications) has actually tended to increase*

It is very important therefore to find the cause for the decline. Last year I suggested that it was due to the scare which developed following the reports which appeared in the medical press during the early months of 1950 which showed that there was a rare but statistically significant relationship between diphtheria immunisation and poliomyelitis in the inoculated limb, and that it would have been well if before these reports appeared their authors had considered whether the harm to the community as a result of the decrease in the number of immunisations did not outweigh the advantage as a result of the reduction in the number of cases of poliomyelitis.

I still think that these reports were the main cause of the decline, although I have no doubt that the success of the immunisations has resulted in decline of the fear of the disease and in fact in reduction of the number of people who have any experience or even knowledge of the disease. A recent report† however tends to lead one to the conclusion that the scare was more among the authorities than the parents, although its authors do not themselves make the calculation from their own figures that justified such a conclusion. In this report it is stated that whereas the proportion immunised at the clinic fell from 62% in 1949 to 49% in 1950, that immunised by the family doctor increased from 35% in 1949 to 47% in 1950, and that immunised at other places increased from 3% in 1949 to 4% in 1950, but this matter is not discussed further, and it is presumed that the family doctor is taking over immunisation from the clinic.

However, if we apply these percentages to the figures for immunisation in 1949 and 1950 (574,000 and 433,000) we find that whereas the number immunised at the clinic fell from 355,880 in 1949 to 212,170 in 1950, or to three fifths, the number immunised by the family doctor remained more or less stationary (203,510 in 1950 as against 200,900 in 1949) and the number immunised at other places remained more or less stationary

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*Monthly Bulletin, Ministry of Health and Public Health Laboratory Service 1952, 51.

†Monthly Bulletin, Ministry of Health and Public Health Laboratory Service 1952, 27.

(17,320 in 1950 as against 17,220 in 1949). No doubt the percentages themselves which were obtained from a sample do not really justify so accurate an estimate of the figures for the country as a whole but the figures are so striking that they are obviously of importance.

What has happened is that the family doctor has rightly concluded that the importance of poliomyelitis in relation to diphtheria immunisation is exaggerated and has continued his activities unchecked, while the clinic has reduced its activities to little more than half. Whether this is mainly the responsibility of the central authority or of the local authority, it is impossible to say. Certainly the complete cessation of publicity measures by the central authority in the summer and autumn of 1950 must have been a very important factor. No doubt individual local authorities assessed the matter at its true value while others grossly exaggerated the dangers. I can only repeat what I said last year, that what is wanted is a statistical investigation to show whether the possibility of death or disablement through poliomyelitis in the immunised is greater than the possibility of death or disablement through diphtheria in the unimmunised, and that there can be very little doubt that it would be shown that our timidity has been entirely unjustified.

SECTION F: PREVALENCE OF, AND CONTROL OVER, INFECTIOUS AND OTHER DISEASES.

Final numbers according to Sex and Age after Corrections of Cases of Infectious and other notifiable Diseases notified during the year ended 31st December, 1951.

	Scarlet fever			Whooping cough			Measles		
	M	F	Total	M	F	Total	M	F	Total
Under 1 year				1	2	3	4	5	9
1-2 years				2	4	6	17	13	30
3-4 years	1	3	4	1	10	11	23	21	44
5-9 years	2	5	7	5	6	11	39	56	95
10-14 years	1		1	1		1	2	3	5
15-24 years							1	2	3
25 and over				1		1	1	3	4
Age unknown									
Total (all ages) ...	4	8	12	11	22	33	87	103	190

	Acute pneumonia			Dysentry			Erysipelas			Meningococcal infection		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Under 5 years ...	1	2	3	3	1	4					1	1
5-14 years ...	1	2	3	5	2	7						
15-44 years ...	7	4	11				1	2	3			
45-64 years ...	7	5	12									
65 and over ...	7	7	14					3	3			
Age unknown												
Total (all ages)	23	20	43	8	3	11	1	5	6		1	1

Puerperal pyrexia	Ophthalmia neonatorum		
Female	Male	Female	Total
1	2		2

INFECTIOUS DISEASES.

As already mentioned, the large number of cases of measles for this Authority is due to the fact that although measles occurs more or less equally each year for the country as a whole, it occurs in each area in alternate years, as it takes two years for the level of immunity in the community to fall, as a result of new births, to the point at which an epidemic can recur. The case of meningitis was in a baby who had moved into the district two days before she took ill, so that the infection originated outside this district, and whose father was an American Serviceman. The cases of ophthalmia neonatorum were non-venereal and the condition cleared up satisfactorily in each case.

I would like to repeat again what I said about whooping cough last year. It is by far the most serious common infections of childhood at the present time. All infections follow waves of virulence and the virulence of scarlet fever is at present no more than that of measles, or possibly even less. Whooping cough therefore stands out above all others and it is good news that a recent statistical investigation* has disclosed that immunisation against whooping cough is of real value. Over a two to three years period of observation 149 of the 3,801 vaccinated children developed whooping cough, whereas 687 of the 3,757 unvaccinated children developed whooping cough, giving attack rates per 1,000 child months of 1.45 and 6.72 respectively, and a reduction in the incidence of the disease of 78%. Among children exposed to whooping cough in their own homes the attack rates were 18.2% in the vaccinated and 87.3% in the unvaccinated groups. The cases that occurred in the vaccinated were on the average less severe and of shorter duration than those in the unvaccinated children. Five vaccines were tested, of which much the most effective were two prepared by the Michigan Department of Health, but the other three were also of value. The further comparative investigations which I mentioned in my last report are not yet complete, but it is hoped that it will soon be possible to undertake a campaign similar to that already undertaken for diphtheria immunisation, and that the Public Health Service will be able to take the same part in the second campaign as it has done in the first.

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* British Medical Journal, 1951, I, 1463.

TUBERCULOSIS.

Age Periods.	New Cases.						Deaths.					
	Respiratory.			Non-Respiratory.			Respiratory.			Non-Respiratory.		
	M	F	Total.	M	F	Total.	M	F	Total.	M	F	Total.
0—												
1— ...				1	1	2						
5— ...				4		4						
15— ...	1	1	2		1	1						
25— ...	2	1	3	1	1	2						
35— ...	1		1									
45— ...	1		1	1		1	1		1			
55— ...	1		1							1		1
65 and upwards												
Total ...	6	2	8	7	3	10	1		1	1		1

Number of cases on the Tuberculosis Register on 31st December, 1951.
(31st December, 1950, in brackets).

	Male.	Female.	Total
Respiratory	24 (19) ...	23 (22) ...	47 (41)
Non Respiratory	11 (6) ...	6 (4) ...	17 (10)
Total	35 (25) ...	27 (26) ...	64 (51)

During the year a complete investigation has been made into all the cases on the Tuberculosis Register and on the list kept by the Chest Physician and a complete new Register has been prepared. As a result the figures shown for last year do not agree with those given in last year's Annual Report but it is hoped that the picture now presented is an accurate one. As I stated last year the Tuberculosis Register is the most difficult to maintain accurate of the records which have to be kept by the Medical Officer of Health. The increase in the number of cases which is shown on the Return is due to the addition of cases which were on the list kept by the Chest Physician but not on the Register. Incidentally 42 cases were removed from the Register as a result of the investigation, although it was not possible to show these on the Return as having existed at the beginning of the year. These were removed from the Register as follows: Recovered 16, Dead 3, Left District 17, Not found in District after adequate search 6. Total 42.

It remains only to repeat again the plea I made last year for the wider use of B.C.G. (Bacille Calmette Guerin) vaccination against tuberculosis, and to quote from some references to this subject which I have noted during the year.

The most interesting was an article on " Tuberculosis in Families with B.C.G. vaccinated and non-vaccinated children."* In this article an approach was made to the problem by examining those families in whom some children had been vaccinated and other not. A search was made in the records of the Nortull's Hospital, the Samariten Hospital, and the Central Tuberculosis Dispensary, Stockholm. In general all families with B.C.G. vaccinated and non-vaccinated children exposed to a known source of infection, and irrespective of whether or not there was any case of tuberculosis among the children, were included. In all there were 16 families, with 22 vaccinated and 22 non-vaccinated children. Among the 22 children in the non-vaccinated group 21 developed primary tuberculosis. In the B.C.G. vaccinated group two at most showed some evidence of superinfection.

In the same article the difference in the incidence of tuberculosis in the vaccinated and non-vaccinated children admitted to Nortull's Hospital was recorded. Of the cases of primary tuberculosis 26 of the 1,352 vaccinated children had developed tuberculosis (1.9%). Twelve of these cases were mild and 14 more or less typical, but some of the latter had been vaccinated so long before that it is very likely the immunity had disappeared. During this 5 year period 8.2% of the non-vaccinated children who had been admitted to the hospital had developed the disease. There were 28 cases of tuberculosis meningitis and/or miliary tuberculosis in the non-vaccinated group and none in the vaccinated group. The number of cases of primary tuberculosis had fallen from 183 admissions in 1945 to 88 in 1949, with an average of 123 in the intervening years.

At a Conference on Infectious Diseases held in Copenhagen during the week 2nd-6th July, 1951, Dr. Winge, Dr. Torning and Dr. Jensen all referred to the benefits arising from the use of B.C.G. vaccination in Denmark.† Since 1936 no cases of tuberculous meningitis had been observed in a person successfully converted by B.C.G. vaccination, and Professor Lassen, reporting that for many years in Blegdams Hospital beds had been set aside for cases of primary tuberculosis, stated that in 1949 there were 72 such beds, in 1950 54, and in 1951 18, and that at that time only 10 of these beds were occupied.

In an article on Tuberculosis Control in Denmark‡ it was stated that the death rate from all forms of tuberculosis in Denmark in 1950 was provisionally announced as 14 per 100,000, i.e., less than half of the figure for England and Wales and the lowest ever recorded in any country. Since 1938 deaths from pulmonary tuberculosis had decreased by about 50 per cent. but those from tuberculous meningitis by over 80 per cent. No case of tuberculous meningitis, miliary tuberculosis, or progressive pulmonary tuberculosis had been observed among the children known to the Copenhagen tuberculosis clinic and vaccinated with B.C.G., though some lived in contact with open pulmonary cases.

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* British Medical Journal, 1952, I, 682.

† British Medical Journal, 1951, II, 354.

‡ Bulletin of the National Association for the Prevention of Tuberculosis, 1951, 609.

In this country an appeal was made by the Portsmouth health department that B.C.G. vaccine should be given to all tuberculin negative school-leavers.§ Authority was requested for the Mass Radiography Unit, which already had the co-operation required with this group of the population, to commence this work, but permission was refused. Here, in spite of 20 years Scandinavian experience we continue to experiment with the adminstration of B.C.G. vaccine to medical students, nurses, and tuberculin-negative contacts of cases of tuberculosis only. What is wanted in this case also is a campaign similar to that already undertaken for diphtheria immunisation and again it is hoped that the Public Health Service will be able to take the same part in this campaign as it has done in that for diphtheria immunisation.

National Assistance Act, 1948.

Section 47—Removal to suitable premises of persons in need of care and attention.

Action has been taken by the Council under this Section at the request of one of the general practitioners in the district, in respect of one woman who was suffering from severe microcytic anaemia (haemoglobin 25%) and also extensive stagnation ulcers of both lower legs, and who was in need of hospital treatment to which she would not consent. It was ordered by the Court that she should be detained in a Long-Stay Hospital for a period of three months. At the end of the year this period had not expired but she had improved since admission and was willing to stay until her treatment was completed.

FOOD POISONING OUTBREAKS.

An outbreak of Food Poisoning occurred at Hannington and Overton schools on 8th June, 1951. 143 cases occurred with no deaths, and the organism responsible was salmonella enteritidis. The food involved was the school meal for the previous day, but the actual article of food responsible was not ascertained. The food was prepared at the Basingstoke Cooking Depot which is not in this District and there was a widespread outbreak of food poisoning in schools served by this Depot, none of which are in this District with the exception of these two and Baughurst, which was closed that day. It was considered that the probable cause was infected meat delivered to the Cooking Depot, as the high proportion of those at risk infected the severity of the symptoms and the short interval between the ingestion of the food and the onset of the symptoms suggested a dosage of infection too high for it to have developed between the time of the preparation of the food and that of its ingestion.

CLEAN FOOD CAMPAIGNS.

Film Shows and Discussions on Health Education including Clean Food were offered during the year to a number of existing organisations and given to those that accepted the offer.

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§ Medical Officer, 1951, II, 175.

ANNUAL REPORT OF THE CHIEF SANITARY INSPECTOR FOR THE YEAR 1951.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present to you my Annual Report of the Sanitary and other work carried out by your Sanitary Inspectors during the year ending 31st December, 1951.

Summary of Inspections.

Visits made in connection with infectious diseases and disinfections carried out	86
Inspections of Butchers and other Food Shops	98
Inspections of Dairies	40
Visits in connection with Water Supplies	127
Inspections of Bakehouses	6
Inspections of Fried Fish Shops	26
Inspections of Catering Establishments	52
Inspections of Factories	15
Inspections of Council Houses	141
Re-inspection of Council Houses in connection with repairs	1113
Inspections in connection with Building Licences	93
Inspection of New Buildings, including drainage works and testing of drains	270
Visits to the Council's Housing Sites and Inspections of works of construction	3565
Inspections in connection with the Petroleum Acts	7
Inspections of Ice Cream Premises	7
Complaints Investigated	29
Houses inspected under the Public Health Act, 1936	281
Interviews with owners	26
Re-visits to property under notice	106
Inspections under the Housing Act, 1936	106
Inspections under the Rats and Mice Act	1737
Re-inspections and treatments carried out under the Rats and Mice Acts	654
Inspections of Requisitioned Properties	113
Disinfestations carried out	12
Inspections of Workshops	11
Inspections under the Shops Acts	12
Milk Samples taken	13
Milk Bottle Samples taken	6
Inspections in connection with Food Poisoning	51
Inspections of Schools	16
Inspections in connection with Moveable Dwellings	47
Inspections of Licensed Premises	9
Maintenance of Council Houses—Contract Inspections	187
Miscellaneous Inspections	158
Total number of Inspections and Visits	9220

Housing.

ROUTINE HOUSING INSPECTIONS CARRIED OUT UNDER THE HOUSING AND PUBLIC HEALTH ACTS OF 1936.

Number of Routine Inspections (Housing Act, 1936)	106
Number of Houses Inspected under the Public Health Act, 1936 ...	281
Number of Informal Visits served	4
Number of visits after the service of notices	106
Total number of Housing Inspections for all purposes	493

Housing Inspections—Public Health Act, 1936.

As a result of inspections under the above Act, the following defects have been brought to the attention of owners, and have been remedied:

Defective Sinks	3	Defective W.C. pans	1
Defective Roofs	6	Defective Cookers	1
Defective Septic Tanks ...	1	Defective Well Linings ...	1
Defective Floors	4	Defective Drainage	5
Defective Windows	2	Defective Water Supply ...	1
Defective Walls	3	Defective Ceilings	2

Total number of Council Houses and Requisitioned Properties in each Parish at 31st December, 1951.

Parish.	Council Houses.	Requisitioned Property.
Ashmansworth	6	—
Baughurst	12	3
Burghclere	36	1
East Woodhay	25	6
Ecchinswell	12	101
Highclere	18	2
Hurstbourne Priors	—	—
Kingsclere	177	5
Laverstoke	—	—
Litchfield & Woodcott	—	—
Newtown	—	—
Overton	178	—
St. Mary Bourne	56	2
Tadley	34	70
Whitchurch	153	7
Total	707	197

This includes the conversion of the Agricultural Hostel, Basingstoke Road, Kingsclere.

The following houses were erected for the Council in 1951:

PERMANENT HOUSES.

Kingsclere	22	Overton	16
Tadley	7	Whitchurch	12

Total family units provided by the Council 57

Agricultural Hostel, Basingstoke Road, Kingsclere.

The above conversion has now been completed and provides 5 units of accommodation.

Elm Grove, Kingsclere.

The Council are negotiating for the purchase of the above property, with a view to converting it into 7 flats.

PRIVATE BUILDING.

The following houses were erected by Private Enterprise in 1951:

Overton	3	Tadley	3
Burghclere	1	St. Mary Bourne	1
East Woodhay	4	Kingsclere	1

The following conversions were carried out by Private Enterprise in 1951:

St. Mary Bourne	1	Whitchurch	1
Burghclere	1		

Total family units provided by Private Enterprise 16

TOTAL FAMILY UNITS PROVIDED IN DISTRICT IN 1951 ... 73

During the year 1,254 visits were made to Council Houses in connection with maintenance and repairs.

910 inspections were made to requisitioned properties and converted camps.

Building Licensing.

93 inspections were made in connection with building licensing, and 169 licences were issued, with a total value of £37,092. This total includes licences granted for new houses.

Housing Act 1949—Improvement Grants.

Improvement grants under the above Act were made in respect of the undermentioned properties:

	Amount of Grant	Total Grant
The Bee House, Hurstbourne Priors ...	£285	£570
Cherry Tree Farm, Headley	£99 5s.	£198 10s.
Oak Cottage, Baughurst	£287 10s.	£575

Moveable Dwellings (Public Heath Act, 1936).

Twenty-two applications were received to erect station and use Moveable Dwellings. In each case permission was given. These moveable dwellings are situated as follows:

Baughurst	1	East Woodhay	1
Highclere	2	Kingsclere	5
Newtown	1	Overton	2
St. Mary Bourne	1	Tadley	5
Whitchurch	1		

Plans Submitted for Approval.

Number of Plans Submitted ...	149
Number of Plans Approved ...	134 (Byelaws only).

Fifteen plans (being site plans, advertisement situation plans, etc.) were not subject to approval under the Council's Building Byelaws, but were forwarded to the Country Planning Authority for approval under the Town and Country Planning Act, 1947.

Repairs and Maintenance of Council Houses.

The following Council Houses were painted externally during the year:

Ashmansworth	6	Highclere	6
Kingsclere	18	Overton	42
St. Mary Bourne	9	Tadley	4
Whitchurch	20		

Repairs to Council Houses carried out during the year are listed hereunder.

Repairs to Fireplaces and Cooking Stoves	133
Repairs to Doors	128
Repairs to Drainage Systems	147
Repairs to Coppers	57
Repairs to Sinks	13
Repairs to Water Services	67
Repairs to Roofs	84
Repairs to Windows	60
Repairs to Ceilings	12
Repairs to Electricity Supplies	28
Repairs to abate Dampness in Walls	3
Repairs to Blocked Drains	10
Repairs to Staircases	2
Repairs to Floors	4
Lavatory Pails renewed	23
Dustbins issued	81
Internal decorating carried out	3

Repairs to requisitoned properties:

Repairs to Roofs	130
Repairs to Windows	29
Repairs to Electricty Supplies	54
Repairs to Doors	27
Repairs to Fireplaces and Cooking Stoves	51
Repairs to Drainage Systems	21
Clearance of Blocked Drains	18
Repairs to Water Services	19
Internal decorating carried out	23

FOOD SUPPLIES.

Milk.

During the year the standard of cleanliness of dairies was maintained. Three dairies were reconstructed (details given hereunder) and in another dairy work of reconstruction was put in hand. In this district a high standard of dairy hygiene has been reached and the co-operation between distributors and inspectors is excellent. There are now only seven dairies which are the responsibility of this authority and these are situated at

Overton	3	Whitchurch	2
Kingsclere	1	East Woodhay	1

Dairies Reconstructed.

Messrs. W. Horne and Sons, Whitchurch.
H. A. Berry, Dellands, Overton.
R. Wheatley, High Street, Overton.

Milk (Special Designation) (Raw Milk) Regulations, 1949.

Licences under the above regulations to sell Tuberculin Tested milk were issued to 12 applicants, eight of whom were selling from premises outside the district.

W. C. Trice, Ball Hill, East Woodhay.
Messrs. Swinford & Crowe, Overton.
H. A. Berry, Overton.
W. Horne & Son, Whitchurch.
H. A. Job, Didcot.
G. B. Meier, Basingstoke.
Heatherwold Dairy, Newbury.
Lovell's Dairy, Andover.
Hants Dairy, Basingstoke.
G. Rollings & Sons, Brimpton.
F. C. Arlott, Aldermaston.
Andover Creameries, Andover.

Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949.

Licences to sell pasteurised milk were issued to thirteen applicants and of these eight were for the sale of pasteurised milk from premises outside the district. There were no applications to sell sterilised milk.

A. H. Jenkins, Newtown.
G. B. Peck, Tadley,
Swinford & Crowe, Overton.
H. A. Berry, Overton.
W. Horne & Sons, Whitchurch.
H. A. Job, Didcot.
G. B. Meier, Basingstoke.
Heatherwold Dairy, Newbury.
Andover Co-operative Society, Andover
Lovell's Dairy, Andover.
Hants Dairy, Basingstoke.
G. Rollings & Sons, Brimpton.
Andover Creameries, Andover.

Milk Samples and Milk Bottle Samples.

Thirteen samples of milk and six milk bottle samples were sent to the Laboratory for bacteriological examination during the year. Details are given herewith:—

Milk Samples—

A. M. Ware, Whitchurch	1 Satisfactory
H. R. Nunn, Kingsclere	7 Satisfactory 3 Unsatisfactory
R. Wheatley, Overton	1 Satisfactory 1 Unsatisfactory

Milk Bottle Samples—

Messrs. Swinford & Crowe, Overton ...	3 Satisfactory
H. R. Nunn, Kingsclere	1 Satisfactory 2 Unsatisfactory

Food and Drugs Act, 1938—Section 14.

There are now 41 premises registered for the sale and storage of ice cream. No manufacture is being carried out and all ice cream is wrapped before delivery.

Kingsclere ...	8	Burghclere	1
Highclere	3	St. Mary Bourne	3
Newtown	1	Overton	6
Tadley	3	Whitchurch	12
East Woodhay ...	1	Ecchinswell	2
Ashmansworth ...	1		

Meat and Food.

FOOD PREMISES WITHIN THE DISTRICT.

Parish	Knackers Yards.	Butchers Shops.	Bake Houses.	Fried Fish Shops.	Sausage Manufacturers.	Jam and Fruit Preserving.
Baughurst	—	—	1	—	—	—
East Woodhay	—	—	1	—	—	—
Kingsclere	—	2	4	—	2	—
Overton	—	4	1	2	4	—
St. Mary Bourne	1	1	2	1	1	—
Tadley	—	1	1	1	1	—
Whitchurch	—	6	2	3	6	1
Total ...	1	14	12	7	14	1

Number of inspections to Butchers and other Food Shops ... 130

Diseased or Unsound Foodstuffs Condemned.

Ham	41 lbs.	Bacon	7½lbs.
Pork Sausages ...	72 lbs.	Fish Cakes	54 lbs.
Cheese	23 lbs.	Fish	11 lbs.
Meat (tinned)	63¾lbs.	Pork (tinned)	½lb.
Salmon (tinned) ...	1½lbs.	Peas (tinned)	8 lbs.
Beans (tinned) ...	3¼lbs.	Soup (tinned)	2 lbs.
Spaghetti (tinned) ...	1½lbs.		

Total weight of Foodstuffs condemned ... 2cwt. 2qrs. 9lbs.

WATER SUPPLIES

Private Water Supplies.

Sixty-one samples of water were taken from Private Water supplies and submitted for examination, with the following results:

PARISH.	Satisfactory	Unsatisfactory.
Baughurst	3	1
Burghclere	2	1
East Woodhay	4	6
Ecchinswell and Sydmonton	2	1
Highclere	—	3
Kingsclere	3	11
Newtown	1	—
St. Mary Bourne	8	1
Tadley	1	1
Whitchurch	3	6

Where water sample reports indicated that the supply was not suitable for drinking purposes, both owners and occupiers of the dwellings concerned were advised.

The occupiers were asked to boil all water used for drinking purposes until further notice, and owners were notified of any defects to the well which were likely to cause contamination, and instructed to take the necessary steps to abate the nuisance. Points brought to the attention of owners in this way were:

(1) Defective well covers.
(2) Defective well parapets.
(3) Wells to be pumped out and limed.

After these works had been carried out, a further sample was taken from the well for purposes of comparison.

River Test, Whitchurch.

The investigation into the pollution of the River Test continued during the year. Several possible sources were investigated and action taken to prevent oils being discharged into the surface water drains. Investigations are still being carried out in conjunction with the Hampshire River Board.

Laverstoke Watercress Beds.

One sample of water was taken from the above watercress beds and this was found to be satisfactory.

Watercress Beds, Abbey Wells, East Woodhay.

One sample of water was taken from the above watercress beds and this was found to be satisfactory.

Well and Borehole Supplies to Council Houses.

SITUATION.	Satisfactory	Unsatisfactory
Stevens Green, St. Mary Bourne	3	—
Wadwick Lane, St. Mary Bourne	1	—
Batsford, St. Mary Bourne	3	—
Sladen Green, Binley	3	—
Longleaze, Stoke	3	—
Stoke Hollow, St. Mary Bourne	1	—
Highclere Street, Highclere	1	—
Holt Cottages, Ashford Hill	2	—
Townsend, Wolverton	2	—
Total	19	Nil

Public Water Supplies.

The Council own six water undertakings and provide water to the Parishes of Ashmansworth, Burghclere, East Woodhay, Kingsclere, Overton and Whitchurch, and part of the Parish of Ecchinswell. Main water is supplied to 2,378 properties, the remaining properties having their own supply, i.e., well, borehole, etc.

Samples of water were taken from these supplies during the year, and the results are given hereunder.

Ashmansworth Water Supply.

Bacteriological Examination Report.

Date of Collection — 10th October, 1951.

	Per 100 ml.
Probable No. of Coliform Bacilli, MacConkey, 2 days at 37°C.	1
Probable No. of Faecal Coli.	NIL.

Remarks. Date of Report: 13.10.51.

Satisfactory.

(Signed) R. D. MACKENZIE.

Number of Samples taken	4
Number of Premises served	63
Size of Mains	2½ inch

Kingsclere Water Supply (Hannington Pumping Station).
Bacteriological Examination Report.

Date of Collection — 16th August, 1951.

	per 100 ml.
Probable No. of Coliform Bacilli, MacConkey, 2 days at 37°C.	NIL.
Probable No. of Faecal Coli.	NIL.

Remarks. Date of Report: 20.8.51

Very satisfactory.

(Signed) R. D. MACKENZIE.

Number of Samples taken	4
Size of Mains	3 inch.

Kingsclere Water Supply (Kingsclere Pumping Station).
Bacteriological Examination Report.

Date of Collection — 26th November, 1951.

Probable No. of Coliform Bacilli, MacConkey, 2 days at 37°C	NIL.
Probable No. of Faecal Coli.	NIL.

Remarks. Date of Report: 29.11.51.

Very satisfactory.

(Signed) R. D. MACKENZIE.

Number of Samples taken	7
Number of New Connections	27

Number of premises served:

(a) Kingsclere—including Hannington	550
(b) Ecchinswell	96

Size of mains: 4 inch and 3 inch.

Overton Water Supply.
Bacteriological Examination Report.

Date of Collection — 9th October, 1951.

	Per 100 ml.
Probable No. of Coliform Bacilli, MacConkey, 2 days at 37°C.	NIL.
Probable No. of Faecal Coli.	NIL.

Remarks. Date of Report: 11.10.51.

Very satisfactory.

(Signed) R. D. MACKENZIE.

Number of Samples taken	3
Number of New Connections	25
Number of Premises served (this includes properties at Laverstoke)	650

Size of mains: 6 inch, 4 inch and 3 inch.

Whitchurch Water Supply.

Bacteriological Examination Report.

Date of Collection — 9th October, 1951.

	Per 100 ml.
Probable No. of Coliform Bacilli, MacConkey, 2 days at 37°C	NIL.
Probable No. of Faecal Coli.	NIL.

Remarks. Date of Report: 11.10.51.

Very satisfactory.

(Signed) R. D. MACKENZIE.

Number of Samples taken	4
Number of Premises served	766
Number of New Connections	23

Size of mains : 6 inch, 4 inch and 3 inch.

Other Public Water Supplies.

Water mains in the parishes of East Woodhay, Burghclere and Newtown have been taken over by this Council from the Newbury Corporation, as also the water supply mains to the part of Ecchinswell at Bishops Green. Water is supplied in bulk by the Newbury Corporation and is delivered to 425 properties.

Mains have now been laid at Haughurst Hill, in the Parishes of Kingsclere and Baughurst, and the supply is taken to 30 properties. This water is at present supplied in bulk by the Mid-Wessex Water Company.

Water to the Parish of Tadley is supplied by the Mid-Wessex Water Company.

South Western Area Water Supply.

Water mains are now being laid in the south western area of the Rural District, the work having commenced in May, 1951.

To date, 91 applications have been received from persons requiring their properties to be connected to this new mains.

REFUSE AND SALVAGE.

During the year approximately 7,945 tons of refuse were collected and deposited at the Council's tips.

The number of dustbins emptied yearly is 295,568, the average number of bins handled by each man being 23,036. The mileage covered for this work during the year is approximately 20,000.

The time is fast approaching when consideration must be given to the purchase of an additional vehicle for refuse collection if we are to maintain the weekly collection of refuse throughout the Rural District.

Another important question arises with regard to the disposal of household refuse. It is becoming increasingly difficult to find suitable tips in the Rural District which can be used economically, and I suggest that further consideration must be given to the provision of a central Refuse Incinerator Plant.

Details of salvage collected during the year were as follows:—

	Tons	cwt.	qrs.	lbs.
Salvaged paper (newspapers, books, cardboard, etc.)	74	9	3	9
Scrap iron and metals	21	7	2	0
Rags	1	17	3	4
Bones		9	1	18
Bottles	508 dozen			

The income gained from the sale of this material was £997 17s. 2d.

Employees in this department are:—

S.D. Freighter Drivers ...	2	Salvage Balers	1
Tipmen	2	Lorry Drivers	1
Salvage Loaders	1	Refuse Loaders	4

SEWAGE DISPOSAL.

Sewage Works are situated in the Parishes of Ecchinswell and Sydmonton (shared with Air Ministry), Kingsclere, Laverstoke (Pumping Station only), Overton and Whitchurch.

Number of Premises connected to Sewer.

Kingsclere	219	(includes 23 new connections)
Ecchinswell	101	
Laverstoke	85	(,, 7 ,, ,,)
Overton	423	(,, 21 ,, ,,)
Whitchurch ...	398	(,, 19 ,, ,,)

In the remainder of the District sewage is dealt with by:—

(a) Septic Tank or Cesspool.

(b) Earth Closet.

Parish.	Earth Closet.	Septic Tank.
Ashmansworth	46	31
Baughurst	182	68
Burghclere	197	106
East Woodhay	373	140
Ecchinswell and Sydmonton	145	23
Highclere	93	68
Hurstbourne Priors	121	10
Kingsclere	478	146
Laverstoke	46	—
Litchfield and Woodcott	43	15
Newtown	44	30
Overton	218	76
St. Mary Bourne	158	196
Tadley	376	96
Whitchurch	324	39

PETROLEUM STORES.

Licences to store petroleum spirit were issued to 75 applicants, situated as under:

Ashmansworth	1	Baughurst	5
Burghclere	3	East Woodhay	5
Ecchinswell & Sydmonton	3	Highclere	5
Hurstbourne Priors	2	Kingsclere	13
Newtown	1	Overton	12
St. Mary Bourne	12	Tadley	1
Whitchurch	12		

Total amount of Petroleum Stored under licence in district ... 68,660 gals.

Two licences were issued for the storage of Calcium Carbide, one in the Parish of Kingsclere and one at Baughurst.

Total amount of Calcium Carbide stored ... ... 672 lbs.

GAME LICENCES.

Issued for the year ending 31st December, 1951 12

RODENT CONTROL.

Visits in search of rat and mouse infestations were made to 1,737 properties and destruction work was carried out on 654 properties.

As a result 409 dead rats were collected and the estimated kill was between three and four thousand.

The following amounts of bait and poisons were used: —

Ruskit	17 cwts.	Red Squill Powder	54 lbs.
Zinc Phosphide	14 lbs.		

NUISANCES.

It has been necessary to deal with 29 complaints. The nuisances dealt with included offensive accumulations, blocked drains, dirty pigsties, etc.

FACTORIES.

The following factories are situated in the Rural District:—

Paper Mills	2
Gas Works	2
Jam Factories	1
Mineral Water Works	1
Soapworks	1
Garage and Motor Engineering Establishments	18
Silk Mills	1
Joinery Works	4
Laundries	2
Shoe Repair Shops	1
Blacksmiths' Works	3
Agricultural Engineers	2
Dry Cleaners	1
Total	39

CONCLUSION.

I take this opportunity of expressing my appreciation to the Council for the consideration and support given to me during the year, also to Dr. J. Sleigh, the Medical Officer of Health, the Clerk of the Council, Mr. F. A. H. Keates and his staff for their interest and valuable advice in connection with my varied duties.

I am, Ladies and Gentlemen,

Your obedient servant,

REGINALD A. OVER,
Chief Sanitary Inspector and Surveyor.